Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:	U1			
		HAL012005		B. WING		06/21/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MORGA	NTON LONG TERM C	ARE FACILITY	T UNION ST TON, NC 28				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
C 000	C 000 Initial Comments		C 000				
	on 6-21-2016.	Construction by Dennis Harrell					
	Records indicate this facility was first licensed on 7-1-1983. The owner stated that 7-1-1983 was when he bought the facility and that is was built and first operated in 1957. This date was verified by the Burke County property tax GIS records. The facility is licensed for 20 residents and was						
surveyed using the 1967 NC State Building Code, the 1971 Minimum and Desired Standards and Regulations for Homes for the Aged and Infirm and the applicable portions of the current Rules for Adult Care Homes of Seven or More Beds.							
C 166	Housekeeping-Mai	ntained Free of Hazards	C 166				
	FURNISHINGS (a) Adult care home (5) be maintained orderly manner, free hazards;	806 HOUSEKEEPING AND					
	1. Based on obser flexible toys and stuthe hand rail in the The toys obstructed	et as evidenced by: vation, there were many uffed animals wrapped around corridor near the front door. d access to portions of the cause a resident to fall.					
	padlock on the outs the dining room. L be operated from o	vation there was a hasp and side of the door to a closet off atching hardware that can only one side of the door, such as s, present the possibility that					

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED		
		HAL012005		B. WING		06/2	1/2016
					STATE, ZIP CODE	1 00.2	
	NTON LONG TERM C	ADE EACH ITY		T UNION ST			
WORGAI	NION LONG TERM CA	ARE FACILITY	MORGAN	TON, NC 28	655		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCII ' MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 166	Continued From page 1		C 166				
	someone could be	trapped in the room					
	3. Based on observation, the toilet paper holder was missing in the tub bathroom. The missing paper holder exposed 2 hangers that were a laceration hazard.						
C 189	Building Equipment Maintained Safe, Operating			C 189			
	SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS (a) The building an mechanical, and plu care home shall be operating condition. (k) This Rule shall facilities with the ex which shall not app	11 OTHER d all fire safety, electronic displayment is maintained in a saft. apply to new and exception of Paragrap	n an adult e and kisting oh (e)				
	This Rule is not me 1. Based on observe combination exit and corridor not work whemergency lights the least 90 minutes cound staff. Findings include: a. The combination combination exit and corridor near the kith b. The combination exit and corridor near room 2. Based on observe combination of the combination exit and corridor near room	vation, battery back, and emergency lights hen tested. Battery hat will not work proposed endanger the result of the emergency light in the battery backed-up and emergency light in the battery backed-up and emergency light in the	in the powered perly for at esidents				
	fire rated walls and/ in locations. Holes	or ceilings were cor	mpromised				

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED		
		HAL012005	B. WING		06/21	/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/21	12016	
		1300 FAS	T UNION ST				
MORGANTON LONG TERM CARE FACILITY MORGANTON, NC 28655							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
C 189	Continued From pa	ge 2	C 189				
	one-hour fire rated possibility that a fire quickly spread to of Findings include: a. Hole in the wall	als approved for use in construction present the e that begins in one space can ther areas of the facility. behind the door in room 7, and at a water line in the					
C 199	C 199 Exhaust Ventilation		C 199				
	SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (g) The spaces listed in this Paragraph shall be provided with exhaust ventilation at the rate of two cubic feet per minute per square foot. This requirement does not apply to facilities licensed before April 1, 1984, with natural ventilation in these specified spaces: (1) soiled linen storage; (2) soil utility room; (3) bathrooms and toilet rooms; (4) housekeeping closets; and (5) laundry area. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities.						
	maintain required e Non-functioning ext unhealthy buildup o bacteria. Findings include; a. The exhaust fan employee bathroom	ion the facility failed to exhaust in a working condition. haust could cause an of moisture and possibly was not working in the					

Division of Health Service Regulation

STATE FORM 6899 1R2621 If continuation sheet 3 of 4

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 (X3) DAT CON			SURVEY		
		HAL012005	B. WING		06/2	21/2016		
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
MORGA	MORGANTON LONG TERM CARE FACILITY 1300 EAST UNION STREET MORGANTON, NC 28655							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE		
C 199	Continued From pa	ige 3	C 199					
ì	bathroom.							

Division of Health Service Regulation